DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES
CENTERS FOR	MEDICARE	& MEDICAID	SERVICES

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155248	B. WIN	G		03/24/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				I	ST CHANDLER AVE		
	I LIVING CENTER-E	BRENTWOOD		EVANS	VILLE, IN47713		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΤE	COMPLETION DATE
					·		DATE
F0000		r the Investigation of	F00	00			
	Complaint IN000	087956.					
		conjunction with the					
	Post Survey Revisit (PSR) to the Investigation of Complaint IN00083702 completed on January 12, 2011.						
		conjunction with the					
	PSR to the Investigation of Complaints IN00085197 and IN00085238 completed on February 2, 2011.						
	•	087956 - Substantiated.					
		iciencies related to the					
	allegations are ci	ted at F246.					
	Unrelated deficie	encies are cited.					
	Survey dates:						
	March 23 and 24	-, 2011					
	P 317	000150					
	Facility number:						
	Provider number						
	AIM number: 10	0267510					
	C						
	Survey team:	DM					
	Anne Marie Cray	ys KN					
	Canqua had to						
	Census bed type:						
	SNF/NF: 82						
	Total: 82						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LFRK11

Facility ID:

000152

TITLE

If continuation sheet

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155248			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/24/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE ST CHANDLER AVE SVILLE, IN47713	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
	Census payor typ Medicare: 9 Medicaid: 65 Other: 8 Total: 82 Sample: 11 These deficienci findings in accor				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155248	B. WIN			03/24/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			30 EAS	T CHANDLER AVE		
	LIVING CENTER-				VILLE, IN47713		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1710		1) All interviewable residents		DATE
F0246		nterview and record review, the		46	were interviewed regarding		04/08/2011
SS=D	_	ensure call lights were	alleged concerns of call lights				
		nely manner, for 3 of 4			being answered in a timely		
		ewed regarding call lights,			manner.2) All residents with th		
	in a sample of 11	. Residents H, I, and K			potential of being affected by t	he	
	Findings include	:		alleged concerns of call lights being answered in a timely manner were identified and interviewed.3) Education was			
	1. On 3/23/11 at	12:45 P.M., the			given to staff regarding the ma	tter	
	Administrator pr				of answering call lights in a tim		
		enviouseble Regidents " Regidents II I manner. Additional observations		ns			
	and K were on this list.				will be made by evening managers two times weekly.		
	und it were on th	115 1150.			Audits will be implemented two	,	
	In a confidential	interview with Resident			times weekly by SSD or design		
		dicated call lights were			to ensure call lights are being		
	· ·	ered timely, and if they			answered in a timely manner.4	1)	
	<u>-</u>	-			Corrective actions will be moiitored by SSD or designee		
		s the staff say they will			five times weekly and will be		
	be right back, and	d they don't come back."			monitored by the ED in month	y in	
					QAA meeting.Audits will be		
		interview with Resident			performed two times weekly for		
	· ·	cated call lights were not			months, and 1 time weekly for		
	•	, and it "was worse on			additional 3 months, or longer additional corrections are	П	
	2nd shift." Resid	ent I indicated that she			necessary.		
	had waited for as	s long as 1 hour. Resident					
	I indicated, "The	CNAs on 2nd shift seem					
	to disappear." Re	esident I indicated when					
		tance, she could not find					
	staff.	•					
	In a confidential	interview with Resident					
	K, Resident K indicated, "Call lights were a problem. 2nd shift more so." Resident K						
	-	ht response averaged "1/2					
	mulcated can fig	in response averaged 1/2					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		NSTRUCTION	(X3) DATE S COMPL	
		155248	B. WIN			03/24/2	011
	PROVIDER OR SUPPLIER		•	30 EAS	ADDRESS, CITY, STATE, ZIP CODE T CHANDLER AVE VILLE, IN47713		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hour."						
	2. On 3/24/11 at 9 Administrator prominutes for the pminutes included 1/18/11: "Old Eanswered in a tim Issue Resolved to NoNew Busine not answered tim will be right back who share the condition of the share the share the condition of the share the sha	Business: Call lights nely manner. Was the o Your Satisfaction? Ses: Call lights are still nely. Tired of hearing I of the county of the count					

000152

PRINTED: 04/07/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155248		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/24/2011		
	PROVIDER OR SUPPLIEF		STREET A	ADDRESS, CITY, STATE, ZIP CODE ST CHANDLER AVE VILLE, IN47713		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	won't help [with] they turn the light they will get a C Resolved to You enough staff/help BusinessWhen call light but dor problemNumb the concern: 7 ou 3. In confidentia members, 2 of 3 there was not encare for the reside "There is not encare for the residents are still minutes till 8." S is not enough he real bad lately."	light is on they answer I't come back to solve er of residents who share				

000152

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC		COMPL	ETED
		155248	B. WIN			03/24/2	011
			B. (111)		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF P	ROVIDER OR SUPPLIER				T CHANDLER AVE		
GOLDEN	I LIVING CENTER-	BRENTWOOD			VILLE, IN47713		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279		ew and record review, the	F02	79	F279		04/08/2011
SS=D	facility failed to	ensure a plan of care was			1) Corrective action of alleged deficient practice was taken for		
	developed regard	ling fall prevention, for a			resident "C", and a plan of care w	/as	
	resident assessed	as being at risk for falls,			initiated. All staff were educated		
	for 1 of 1 residen	nt reviewed for falls, in a			disciplinary action was given to		
	sample of 11. Re	-			immediate staff involved.		
	r				2) All other residents with the		
	Findings include: 1. On 3/24/11 at 10:45 A.M., the Director of Nursing provided the current facility				potential to be affected by the alle		
					deficient practice were identified		
					corrections were made as necessa	-	
					3) All appropriate staff was educating the area of the alleged deficien		
					in the area of the alleged deficien practice. Audits will be conducted		
		Management," dated			daily on new admissions in clinic		
		icy included: "The			start-up to ensure a plan of care is		
	facility implement	nts the falls prevention			put into place for fall prevention.		
	and intervention	program including:			4) Corrective actions will be		
	During preadmis	sion intake, determine if			monitored by the DNS or designe	ee in	
	• •	dent has a history of			clinical start-up twice weekly for		
	•	eady in gait. Assure that			months and 1 time weekly for an		
	_	all prevention equipment			additional 3 months, or longer if		
		n place prior to the			additional corrections are needed This will also be monitored by the		
					ED in monthly QAA meetings.	C	
	resident's admiss	•			LD in monthly Quarmeetings.		
		tted residents are assessed					
	_	eans of the Clinical					
		Immediate Plan of Care					
	at Risk for Falls	is initiated. At risk					
	residents are iden	ntified through a 'fall					
	alert' communica	ation system to care					
		disciplinary team					
	_	prevention plan of care					
	for residents 'at r	-					
	131 Testaents at 1	101 14110					
	2. The clinical re	cord of Resident C was					
	reviewed on 3/23	3/11 at 2:00 P.M. The					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155248		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155248	B. WING			03/24/2	011
	PROVIDER OR SUPPLIER			30 EAS	DDRESS, CITY, STATE, ZIP CODE T CHANDLER AVE VILLE, IN47713		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	resident was adm 2/25/11 with diag limited to, closed hospital history a resident had falle her hip. An admission nu Health Status," d "Memory prob NWB [non weigh debilitationRisiconfusion, 1-2 fa Chair boundLe problem while st while walking, L weaknessTotal deems resident a Nursing Progress following notation 1/2/27/11 at 7:24 P some confusion 1 lying on side four foot lasceration [aitted to the facility on gnoses including, but not a fracture left hip. A and physical indicated the en at home and fractured arising note, the "Clinical ated 2/25/11, indicated: lemBalance unsteady, but bearing], general at for falls: Intermittent lls in past 6 months, gally blind, Balance anding, Balance problem ower extremity score of 10 or above trisk, Total Score 24"	1	- 1	CROSS-REFERENCED TO THE APPROPRIA	TE	
	[sic] to er for eva A Hospital emerg 2/27/11, indicate	l order received to asetnd al and tx [treat]." gency room note, dated d, "The patient was after arrival. She fallen					

Facility ID:

PRINTED: 04/07/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE S COMPL	
		155248	A. BUI B. WIN	LDING IG		03/24/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER			30 EAS	T CHANDLER AVE		
	I LIVING CENTER-E			EVANS'	VILLE, IN47713		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		t the nursing home and	+	IAG	,		DAIL
		ontusions. Her main					
		eared to be a laceration to					
		e right footThe skin					
	was very thin and fragile and was edematous and felt that sutures would not						
	be usable at this time. Long quarter inch						
	Steri-Strips were placed over the						
	laceration and the skin edges were reapproximated. A dressing was applied and also placed a short leg OCL splint to decrease range of motion and risk of						
	_						
		openI did order a bed					
	•	r from getting out of bed					
		herself again. Final					
		dental fall with multiple					
		[centimeter] right dorsal					
	foot laceration	"					
	An "Immediate l	Plan of Care At Risk For					
		3/11, indicated: "Problem,					
		elated to: Fell in the past					
		rentions included: "Call					
	-	ncourage rest periods					
	_	ertiringEvaluate need					
	for bed alarm"	~					
	101 004 uiuiiii						
	A plan of care res	garding fall prevention					
	-	was lacking in the clinical					
	record.	Č					
	On 3/23/11 at 2:2	20 P.M., the Director of					
		d the admitting nurse was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LFRK11

Facility ID:

000152 If co

If continuation sheet Page 8 of 13

		IDENTIFICATION NUMBER: 155248	A. BUILDING		COMP 03/24/	LETED
		100240	B. WING	LANDARIO COMPANIO CONTRACTOR CONT		
NAME OF F	PROVIDER OR SUPPLIER	8	I	TADDRESS, CITY, STATE, ZIP CODE ST CHANDLER AVE	,	
	I LIVING CENTER-I		EVAN	SVILLE, IN47713		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	COMPLETION DATE
IAG		nitiating a plan of care on	IAG	BETTELLINETY		DATE
	_	g fall prevention. The				
		he Unit Manager should				
		ensure care plans were				
		nterventions implemented.				
	_	ted the admitting nurse				
		ated on facility policy.				
	indicate to an indicate position.					
	3.1-35(a)					
	,					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		ONSTRUCTION	(X3) DATE S COMPL	
		155248	B. WIN			03/24/2	011
GOLDEN	PROVIDER OR SUPPLIER	BRENTWOOD		30 EAS	ADDRESS, CITY, STATE, ZIP CODE ST CHANDLER AVE VILLE, IN47713		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F02	TAG	F323		DATE
F0323		ew and record review, the	F03	23	1) Corrective actions were put int	·0	04/08/2011
SS=D	_	develop a plan to prevent			place for resident "C" for the allege		
	_	upervision and/or			deficient practice. A plan of care	-	
	· ·	, for a resident assessed			initiated to include a low bed, bed	i	
	as being at risk fo				alarm, mat placed on floor and		
		d for falls, in a sample of			padding was installed on bed tabl All staff were educated and	e.	
	11. Resident C.				disciplinary action was given to		
					immediate staff involved.		
	Findings include:				2) All other residents with the		
					potential to be affected by the alle	_	
	1. On 3/24/11 at	10:45 A.M., the Director			deficient practice were identified		
	of Nursing provid	ded the current facility			corrections were made as necessa	-	
	policy on "Falls I	Management," dated			3) All appropriate staff was educating the area of the alleged deficien		
	4/24/06. The poli	icy included: "The			practice. Education was given to	·	
	facility implemen	nts the falls prevention			appropriate staff in regards to		
		program including:			supervision of residents and use of	of	
	During preadmis	sion intake, determine if			assistive devices for residents		
		dent has a history of			deemed as a fall risk Audits will		
	•	eady in gait. Assure that			conducted daily on new admissio in clinical start-up to ensure a pla		
	-	all prevention equipment			care is put into place for those at		
		n place prior to the			for falls.		
	resident's admiss				4) Corrective actions will be		
		ted residents are assessed			monitored by the DNS or designe		
		eans of the Clinical			clinical start-up twice weekly for	3	
		Immediate Plan of Care			months and 1 time weekly for 3 additional months, or longer if		
		is initiated. At risk			additional corrections are needed.		
		ntified through a 'fall			This will also be monitored by the		
		tion system to care			ED in monthly QAA meetings.		
		disciplinary team					
	_	prevention plan of care					
	for residents 'at r						
	ioi residents at r	ISK TOT TAITS					
	2. The clinical re	cord of Resident C was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155248		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPL	ETED	
		155248	B. WIN	IG		03/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-I	BRENTWOOD		1	T CHANDLER AVE VILLE, IN47713		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		3/11 at 2:00 P.M. The					
		nitted to the facility on					
	`	gnoses including, but not					
	limited to, closed fracture left hip. A hospital history and physical indicated the resident had fallen at home and fractured						
	her hip.						
	An admission nursing note, the "Clinical						
	Health Status," dated 2/25/11, indicated: "Memory problemBalance unsteady,						
	NWB [non weight bearing], general						
		k for falls: Intermittent					
		lls in past 6 months,					
		gally blind, Balance					
		• •					
	-	anding, Balance problem					
	while walking, L	•					
		score of 10 or above					
	deems resident a	t risk, Total Score 24"					
	Nursing Progress	Notes included the					
	following notation						
	C						
		.M.: "Resident alert and					
		noted this shift resident					
		nd in floor lying on right					
	_	sic] noted to rt [right] top					
	of foot approx 4						
		l order received to asetnd					
	[sic] to er for eva	al and tx [treat]."					
	A Hospital emerg	gency room note, dated					
		d, "The patient was					
	,						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/24/2011			
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BRENTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 30 EAST CHANDLER AVE EVANSVILLE, IN47713					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	evaluated shortly [sic] out of bed a sustained some of injury. [sic] App the dorsum of the was very thin an edematous and fibe usable at this Steri-Strips were laceration and the reapproximated, and also placed a decrease range of tearing the repair alarm to keep he and injured herse Impression, Acceptations. 7 cm foot laceration An "Immediate Falls," dated 2/2: At risk for falls in 30 days" Intervalight available. End aily to avoid ow for bed alarm' A plan of care reprior to 2/28/11 in record.	rafter arrival. She fallen at the nursing home and contusions. Her main eared to be a laceration to be right footThe skin difragile and was celt that sutures would not time. Long quarter inches placed over the eskin edges were. A dressing was applied a short leg OCL splint to firm and risk of ropenI did order a bed or from getting out of bed celf again. Final idental fall with multiple a [centimeter] right dorsal Plan of Care At Risk For 8/11, indicated: "Problem related to: Fell in the past ventions included: "Call checourage rest periods certiringEvaluate need garding fall prevention was lacking in the clinical						
	On 3/23/11 at 2:2	20 P.M., the Director of						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LFRK11 Facility ID:

000152

If continuation sheet

Page 12 of 13

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155248	A. BUILDING B. WING		03/24/2011	
NAME OF F	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-I	BRENTWOOD		ST CHANDLER AVE SVILLE, IN47713		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
	_	d the admitting nurse was				
	•	nitiating a plan of care on g fall prevention. The				
		he Unit Manager should				
	_	ensure care plans were				
	_	terventions implemented. ted the admitting nurse				
		ated on facility policy.				
		•				
	3.1-45(a)(2)					